

CONSENT FOR DENTAL SEALANTS

To be completed by PARENT OR GUARDIAN

Child's Name

Date of Birth

School

Parent/Guardian Name

Teacher

Address

Grade

Home Phone

Cell Phone

County

Does your child receive: **(Please circle yes or no for each)**

Yes No Medicaid

If yes, what is the Medicaid Recipient ID Number: _____

Yes No NC Health Choice

If yes, what is the Health Choice Recipient ID Number: _____

Health history: Has your child had any of the following: **(Please circle yes or no for each)**

Yes No Diabetes

Yes No Seizures

Yes No Latex allergy

Yes No Other allergies (describe) _____

Yes No Asthma If yes and inhaler is used at school, the inhaler must be present during treatment.

Yes No Any other medical conditions (explain if yes) or other comments:

List prescriptions, if any: _____

Check Yes or No. Sign Your Name and Date the Form.

____ Yes, I give:

- My consent for a visual examination of my child's mouth in order to determine which teeth need sealants; and
- My consent for dental sealants to be placed on my child's teeth; and
- Permission for the NC Oral Health Section staff to follow up with the school nurse to clarify questions about my child's health history or dental history.

____ No, I do not want my child to participate.

I understand that the N.C. Oral Health Section staff will let me know if my child needs additional dental care. It is my responsibility to get the additional care. I can call my public health dental hygienist to help me find additional care for my child. I also understand that my child may not be included in this project.

Parent or Guardian Signature

Date

PLEASE RETURN THIS FORM TO YOUR CHILD'S TEACHER TOMORROW IN THE ENVELOPE PROVIDED.
PLEASE SEAL THE ENVELOPE *THANK YOU!*

